WHANGANUI REGIONAL HEALTH NETWORK
ANNUAL PLAN 2019-2020

It is the Whanganui Regional Health Network Board's intent that the organisation has its own annual plan, while continuing to working collaboratively to achieve an overall improvement in the health and wellbeing of our population, through various collaborative strategies; as defined and endorsed by Whanganui Alliance Leadership Team.

Assumptions

That the 2019/2020 Whanganui Regional Health Network (WRHN) annual plan supports the Whanganui DHB district wide annual plan and system level measures framework.

It acknowledges district wide strategic drivers and the enablers to assist in their achievement. These include;

- Equitable outcomes
- Integrated care
- Whanau person centred care
- Partnering for community wellbeing

The plan's intent is broad enough to enable a flexible approach to any local and/or sector wide changes that may occur.

It acknowledges that transformational change is required at all levels to ensure sustainable and equitable access for our population to care and treatment – right place, right time.

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Strategic Driver	Partnership Obligations with WDHB	General Practice Members	Subsidiaries	Partners – Community/ MSD/ARC/NGOs/Rural/ Corrections
Equitable Outcomes	• System level measures • Population health targets • Enrolment in PHO • Access to urgent care services • Distribute timely population information to practices/system • Improve health equity through self-assessment and measurement	• Flexible Funding Pool controls and monitoring to ensure maximum benefit for Maori and high need populations • Identify and provide actions for those eligible and enrolled, but not attending general practice • Culturally responsive workforce through adequate orientation and training • Inequity reporting to Clinical Governance Group (CGG) at practice level, with WRHN supporting practice members who demonstrate significant inequity in access to develop strategies to reduce risk of patients accessing episodic care • Establish health equity assessment process and measure compliance and create a menu of measures General Practice can use to progress priorities	• Open enrolment access to general practice services for unique populations • Review facility and workforce capacity and capability of subsidiary General Practices to respond to future growth for unique populations • Reconnect WRHN patients back to practices from Whanganui Accident & Medical (WAM) and share learnings on rationale for primary appropriate patients presenting at WAM during General Practice opening hours (for non-ACC presentations) • All subsidiary practices undertake equity assessment and there is evidence of a menu of measures that are integrated within each subsidiary performance plan	• Community co-design action shapes General Practice/primary care across the district • Championing across system strategy re alcohol, unhealthy food exercise and housing • Explore partnership opportunities with MSD to support clients who present at WINZ that are not actively engaged with health providers • Provision of leadership to lead transition of Children's Team (Oranga Tamariki) services integrated with FLOW in an authentic Iwi / Provider partnership • Work with rural Iwi leads to agree together what the equity measures will be for each rural subsidiary clinic service

Integrated Care	• Communication strategy results in improved health literacy • Acute demand workstream's drive transformational system change • More connected services for youth • Integrated approach to Clinical Pathway programme to drive new clinical models of care • Development of an Integrated Training Hub relevant to primary, rural and hospital workforce • Establish a sustainable integrated Urgent care model for the district that is inclusive of WRHN and partners, WDHB and NHC	• Timely access to specialist services matches appropriate use of resources • WRHN clinical services provides timely clinical actions/plan/outcomes back to patients and general practice providers • Progress key indicators core to developing a sustainable Health Care Home model for the future • General Practice members are engaged in the design of the sustainable Urgent Care service and agree the options that address a fair and equitable model, where all practice members in the city are contributing	• Piloting MH Psychiatrists/GP and Long Term Conditions nurses/IDT team at Gonville Health • WAM business will operate with ED in a cohesive patient centred way offering excellent communicated processes and high quality care that is delivered in the right place right time	• WRHN participates as a partner in local integrated forums, such as FLOW (Police Family Harm initiative), Oranga Tamariki (Intensive case management children with MSD/OT and NGOs)
Whanau Person Centred Care	• Ruapehu Whanau Transformation • Whanau Ora • Kainga Whanau Ora	• How can we support you in "*What matters to you when you are sick*" • WRHN participation in Kotahitanga Alliance as the programme rolls out locally	• Learning culture to drive Whanau Ora outcomes integrated with general practice • Collective impact pilot focused on whanau living in social housing	• WRHN's profile within the community with other sector agencies is credible and courageous and forward thinking leadership is evident

Partnering for Community Wellbeing (Intersectoral)	• Greater focus on disease prevention and health promotion • Targeted stepped interventions across systems • Workforce development focused on health promotion and illness prevention • Collective health promotion impact	• Engagement in education to move forward self-management • Participation in insectorial collaboration • General Practice supported to consider broader determinants of health	• Participation in intersectorial collaboration • Education and information provided to General Practice, so they are informed and have resources to refer	• Work with Sport Whanganui and Public Health Unit to reflect reality in progressing strengths of Green Prescription • Collective Communications design information that is culturally and clinically appropriate
Enablers	Information systems: • Patient Portal and Shared Care Records – 'Manage My Health' • Clinical pathways • Wellbeing tool • E-referral 'transition of care'	• Flexible funding pool • Strengthened engagement between General Practice members and WRHN leaders • System response to cultural training and coaching • Workforce development plan for primary care • Timely access to big data, which is accessed independently by all practice members	• Transitional underwrite funding if required for WAM	• Explore ways to share cross sector information